SECTION 5 **SUBMITTING CLAIMS TO MEDICAID**

Time Limits for Filing Claims

All Medicaid claims, except inpatient claims and nursing facility claims, must be received by EDS within 365 days of the **first date** of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim.

Submitting Claims on Paper

When completing the paper claim form, use black ink only. Do not submit carbon copies or photocopies, and do not highlight the claim or any portion of the claim. For auditing purposes, all claim information must be visible in an archive copy. EDS uses optical scanning technology to store an electronic image of the claim, and the scanners cannot detect carbon copies, photocopies, or any color of ink other than black. Carbon copies, photocopies, and claims containing a color of ink other than black, including highlighting, will not be processed and will be returned to the provider.

Processing Paper Claims without a Signature

Providers are allowed to file **paper** claims without an original signature on each claim if the provider submits a **Provider Certification for Signature on File** form. (Providers who file claims electronically are not required to complete this form. Refer below to **Submitting Claims Electronically**, below.) Please note that out-of-state providers (providers more than 40 miles from the North Carolina border) are required to have a signature on the claim.

Forms that must be signed must contain the provider's original signature; stamped signatures are not accepted. For group physician/practitioner practices or clinics, each attending provider must sign a certification. Groups whose claims do not require an attending provider number - such as home health agencies, hospitals, and facilities (including adult care) - should have the certification signed by an individual who has authority to sign contracts on behalf of the provider.

To avoid EOB 1350 denials (which indicate that a **Provider Certification for Signature on File form** has not been submitted), please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 prior to submitting claims to verify that the system has been updated.

A copy of the form is available in Appendix G-21 or on the DMA Web site at http://www.dhhs.state.us/dma/forms.html. Fax or mail completed certifications two weeks in advance of submitting claims without a signature.

Submitting Claims Electronically

Providers who plan to submit claims electronically must indicate their intention to do so by agreeing to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement.

The process of submitting claims to Medicaid through electronic media is referred to as Electronic Commerce Services (ECS). EDS will process claims submitted through FTP and asynchronous dial-up.

Billing electronically requires software that complies with the transaction standards mandated by HIPAA. Refer to Section 10, Electronic Commerce Services, for additional information about electronic billing and ECS services.

Billing on the CMS-1500 Claim Form

Listed below are some of the provider types who bill Medicaid using the CMS-1500 claim form:

- Ambulatory surgery center*
- Audiology or speech pathology, physical therapy, occupational therapy, and psychological services, case management services (DSS)
- Certified registered nurse anesthetist*
- Chiropractor*
- Community Alternatives Program
- Durable medical equipment*
- Federally qualified health center*
- Free standing birthing center*
- Head Start
- Health department
- Hearing aid dealer
- HIV case management
- Home infusion therapy
- Independent diagnostic testing facility*
- Independent laboratory*
- Independent mental health provider
- Independent practitioner
- Local education agency
- Mental health center
- Nurse midwife*
- Nurse practitioner*
- Optical supply dealer
- Optometrist*
- Orthotics and prosthetics*
- Personal care services
- Physician*
- Planned Parenthood (non-medical doctor)*
- Podiatrist*
- Portable X-ray
- Private duty nursing services
- Residential evaluation services
- Rural health clinic**

*Some provider types are mandated to bill Medicaid using modifiers. Please refer to the **April 1999 Special Bulletin II,** *Modifiers*, for Medicaid modifier usage guidelines.

**Modifier usage is subject to non-core services only.

Medicaid special bulletins are available on DMA's Web site at http://www.dhhs.state.nc.us/dma.bulletin.htm.

Note: Before billing, please refer to program-specific instructions for completing a claim. These are available on DMA's Web site at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

CMS-1500 Claim Form Instructions

Instructions for completing the standard CMS-1500 claim form are listed below.

Block	Block Name	Explanation
1.	Type of Coverage	Place an (X) in the Medicaid block.
1a.	Insured's ID Number	Enter the recipients 10-character identification number found on the MID card.
2.	Patient's Name	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
3.	Patient's Birth Date Sex	Enter the recipients date of birth using eight digits (e.g., July 19, 1960 would be entered as 07191960). **Note**: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims. Place an (X) in the appropriate block to indicate the recipient's sex (M for male; F for female).
5.	Patient's Address Telephone	Enter the recipient's street address including city, state, and zip code. Entering the recipient's telephone number is optional.
9.	Other Insured's Name	If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement.
10.	Is Patient's Condition Related To: a. Employment? b. Auto Accident? c. Other Accident?	If applicable, check the appropriate block.
15.	If Patient Has Had Same or Similar Illness, Give First Date	Leave blank **EXCEPT** when billing for: **Dialysis Treatment or Supervision**: Enter the dialysis start date. **OB Antepartum Care Package Codes**: Enter the first date recipient care was rendered for current pregnancy. **Health Check**: The next screening date (NSD) may be entered in block 15. If the date the provider enters in block 15 is within the periodicity schedule, the system will keep this date. If the NSD entered by the provider is out-of-range with the periodicity schedule or the provider chooses one of the three options listed

		below, an appropriate NSD will be systematically entered during claims processing according to the Medicaid periodicity schedule. • Leave block 15 blank • Place zeros in block 15 (example-00/00/0000) • Place all ones in block 15 (11/11/1111) **Note for all dates**: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
16.	Dates Patient Unable to Work in Current Occupation "From" and "To"	If billing for postoperative management only (designated by modifier 55 in block 24D), enter the "From" and "To" dates the provider was responsible for recipient's care. If the provider was responsible for care for nonconsecutive periods of time in the follow-up period, multiple claims must be filed. Date spans cannot overlap with dates on another claim. Refer to the **April 1999 Special Bulletin II, Modifiers**, for billing guidelines. Please be aware that Medicaid does not recognize any information in blocks 17 and 17a.
19.	Reserved for Local Use	**For CA Enrollees**: Enter the PCP's referral authorization number. **For Area Mental Health Providers ONLY**: Enter the area mental health program reference number when applicable.
20.	Outside Lab?	Check "yes" or "no." "No" indicates that the lab work was performed in the office.
21.	Diagnosis or Nature of Illness or Injury	The written description of the primary diagnosis is not required unless using diagnosis code V82.9. However, the claim must be ICD-9-CM coded to describe the primary diagnosis.
23.	Prior Authorization Number	Any provider billing for laboratory services must enter the CLIA number in this field. It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
24A.	Date(s) of Service "From" and "To"	Enter the 8-digit date of service in the "From" block. **Example**: Record the date of service January 31, 2006 as 01312006. If the service consecutively spans a period of time, enter the beginning service date in the "From" block and the ending service date in the "To" block.

		Note: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
24B.	Place of Service	Enter the appropriate code from **the Place of Service Code Index** beginning on page 5-6.
24C.	Type of Service	Enter the appropriate code from the **Type of Treatment/Type of Service Code Index** on page 5-10. **Note:** Effective date of processing October 16, 2003, Type of Service is no longer required.
24D.	Procedures, Services or Supplies	Enter the appropriate 5-digit CPT or HCPCS code. **Note**: Providers mandated to bill modifiers may bill up to three modifiers per procedure code, if applicable. Refer to the **April 1999 Special Bulletin II, *Modifiers***, for billing guidelines. Health Check claims may also contain modifiers. Refer to guidelines listed in the **April 2006 Special Bulletin I, *Health Check Billing Guide 2006***.
24F.	Charges	Enter the usual and customary charge for each service rendered.
24G.	Days or Units	Enter the number of visits or units.
24H.	EPSDT Family Plan	If the service is the result of an EPSDT (Health Check) screening referral, enter "E." If the service is related to family planning, enter "F."
26.	Patient's Account No.	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric), but only the first nine characters of this number will appear on the RA.
28.	Total Charge	Enter the total charges. (Medicaid is not responsible for any amount that the recipient is not responsible for if the recipient is private pay or has third party coverage.)
29.	Amount Paid	**Effective with dates of service September 6, 2004**, professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B Reimbursement schedule. **Do not enter Medicare payments on the claim. Attach the Medicare voucher when submitting the claim to Medicaid. Refer to the August 2004 Special**

		Bulletin V, *Medicare Part B Billing*, for detailed instructions.
31.	Signature of Physician or Supplier Including Degrees or Credentials	The physician, supplier, or an authorized representative must either: • sign and date all claims, or • use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or • if a **Provider Certification for Signature on File form** has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
33.	Physician's or Supplier's Billing Name, Address, Zip Code & Phone #.	Enter the billing provider's name, street address including zip code, and telephone number. **PIN #**: Enter the attending physician's or orthotic and prosthetic certified 7-character Medicaid provider number. **GRP #**: Enter the 7-character group provider number used for Medicaid billing purposes. The provider number must correspond to the provider name above (i.e., if billing with a group number, use the group name entered in block 33).

Place of Service Code Index

POS Code	Description	Explanation
00-02	Unassigned	
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	
05	Indian Health Service Free-Standing Facility	
06	Indian Health Service Provider-Based Facility	
07	Tribal 638 Free-Standing Facility	
08	Tribal 638 Provider-Based Facility	
09-10	Unassigned	
11	Office	Location, other than a hospital or nursing facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Home is considered the recipient's private residence, which also includes an adult care home facility.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	
15	Mobile Unit	
16-19	Unassigned	
20	Urgent Care Facility	
21	Inpatient Hospital	A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitative services by or under the supervision of physicians to recipients admitted for a variety of medical conditions.
22	Outpatient Hospital	A section of a hospital that provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitative services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Department – Hospital	A section of a hospital where emergency diagnosis and treatment of illness or injury is

		provided.
24	Ambulatory Surgical Center	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Free-Standing Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborns.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services Military Treatment Facilities (MTF). Also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	
31	Skilled Nursing Facility	
32	Nursing Facility	A facility that provides nursing facility level of care of the elderly and physically disabled adults. This facility provides nursing and related services and rehabilitation services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, that do not include a medical component.
34	Hospice	A facility, other than a recipient's home, in which palliative and supportive care for terminally ill recipients and families is provided.
35-40	Unassigned	
41	Ambulance - Land	
42	Ambulance - Air or Water	
43-48	Unassigned	
49	Independent Clinic	
50	Federally Qualified Health Center	
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	
53	Community Mental Health Center	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined

		area.
54	Intermediate Care Facility/Mentally Retarded	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment of a hospital or nursing facility.
55	Residential Substance Abuse Treatment Facility	
56	Psychiatric Residential Treatment	
57	Non-Residential Substance Abuse Treatment Facility	
58-59	Unassigned	
60	Mass Immunization Center	
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitative nursing, physical therapy, speech pathology, social or psychological services, and orthotic and prosthetic services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	
65	End Stage Renal Disease Treatment Facility	A facility, other than a hospital, that provides dialysis treatment, maintenance, or training to recipients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	
71	State or Local Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility that is located in a medically undeserved rural area and that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	
81	Independent Laboratory	A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician’s office.
82-98	Unassigned	
99	Other Unlisted Facility	Other unlisted facilities not identified above.

Types of Service Index

TOS	Description	Type of Service Conversion in Medicaid Claims Processing System
01	Medical	3
02	Surgical	3
03	Consultation	3
04	Diagnostic X-ray and laboratory, professional component	5
05	Diagnostic laboratory, complete procedure	3
06	Radiation therapy	5
07	Anesthesia	1
08	Assistant at surgery	2
09	Maternity	3
10	Eye exams	3
11	Dental	4
15	Independent practitioners, ambulatory surgery, visual aids, and hearing aids	9
31	Complete procedure (both professional and technical components)	3
E	Durable medical equipment - rental	B
N	Durable medical equipment - new purchase	6
T	Technical component	T
U	Durable medical equipment - used purchase	8

Note: Providers must utilize these TOS codes for the AVRS (1-800-723-4337) inquires that ask for the type of treatment.

Billing on the UB-92 Claim Form

Listed below are some of the provider types who bill on the UB-92 Claim form:

- Adult care home
- Ambulance
- Area mental health center
- Dialysis facility
- Home health agency
- Hospice
- Hospital
- Intermediate care facility for mental retardation
- Nursing facility
- Psychiatric residential treatment facility
- Residential child care facility (Level II, III, and IV)

UB-92 Claim Form Instructions

Instructions for completing the standard UB-92 standard claim are listed below.

Form Locator/Description	**Requirements**	**Explanation**
1. Provider Name/Address	Required	Enter the provider's name as it appears on the RA and up to three lines of the address. **Note:** Do not abbreviate the provider's name.
2. Patient Control Number	Optional	Enter either the recipient control number or medical record number, whichever the provider has selected to appear on their RA. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. Although, this block will accommodate up to 20 characters (alpha or numeric) but only the first 9 characters of this number will appear on the RA.
4. Type of Bill	Required Three Digits	Type of Facility – 1st Digit Hospital……1 Skilled Nursing (SNF)…….2 Home Health……3 Intermediate Care (ICF)……..…….6 Special Facility…….8* *If Type of Facility code 8 (Special Facility) is used, then use Bill Classification for Special Facilities. Bill Classification – 2nd Digit Inpatient (including Medicare Part A)…..…..1 Outpatient……...….3 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)……..…..4 Intermediate Care – Level I Medicaid swing-bed ICF……..….5 Intermediate Care – Level II Medicaid swing-bed SNF……..…6 Subacute Inpatient……..7 Swing Beds Medicaid SNF inappropriate level of care…….……....8 Bill Classification- 2nd Digit (Clinics Only) Rural Health Clinic……....1 Independent and Provider Based FQHC…....3 Outpatient Rehab. Facility/Community Mental Health Center……..4 Comprehensive Outpatient Rehab. Facility....5

Form Locator/Description	**Requirements**	**Explanation**
		Community Mental Health…….6 Bill Classification – 2nd Digit (Special Facilities Only Hospice (nonhospital-based)…….…1 Hospice (hospital-based)……2 Ambulatory Surgery Center……...3 Free Standing Birthing Center……....4
4. Type of Bill, continued	Required Three Digits	Rural Primary Care Hospital……..5 Frequency – 3rd Digit Admit Through Discharge……..1 Interim - First Claim……..2 Interim – Continuing Claim……3 Interim – Last Claim……...4 Late Charges(s) – Only Claim……5 Replacement of Prior Claim……...7 Void/Cancel or Prior Claim……8
5. Federal Tax Number	Required, where applicable	
6. Statement Covers Period "From" and 'Through"	Required	Enter the 8-digit beginning service date in the "From" block. Enter the 8-digit ending service date in the "Through" block. Example: Record the date of service January 31, 2006 as 01312006. Note: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
7. Covered Days	Required (Hospital/Nursing Home)	Indicate the total number of days the provider is billing on this claim form.
9. Coinsurance Days	Required, where applicable	Indicate any co-insurance days during the period the provider is billing on this claim form.
10. Lifetime Reserve Days	Required, where applicable	Indicate any lifetime reserve days used for this period.
11.	Required, where applicable	For electronic claims for services provided to CA enrollees, enter the PCP's referral authorization number here. For paper claims, enter the PCP referral authorization number in form locator 83b.
12. Patient Name	Required	Enter the recipient's full name exactly as shown on the MID card (last name, first name, middl initial).
13. Patient Address	Required	Enter the recipient's street address including city, state, and zip code.
14. Patient Birthday	Required	Enter the recipient's date of birth using eight digits. Example: July 19, 1960 would be entered as 07191960.

<table>
<tr><th>Form Locator/Description</th><th>Requirements</th><th>Explanation</th></tr>
<tr><td></td><td></td><td>Note: A 2-digit year is acceptable on paper claims. A 4-digit year is required for electronic claims.</td></tr>
<tr><td>15. Patient Sex</td><td>Required</td><td>Enter on alpha character indicating the sex of the recipient. Valid characters are “M”, “F”, or “U.”</td></tr>
<tr><td>17. Admission Date</td><td>Required</td><td>Enter the eight-digit date that the recipient was admitted.
Example: Record the date January 31, 2004 as 01312004.
Note: A 2-digit year is acceptable on paper claims. A 4-digit year is required for electronic claims.</td></tr>
<tr><td>18. Admission Hour</td><td>Required (Hospital, Ambulance)</td><td>For multiple outpatient visits on the same day, indicate the admission hour and submit each visit on a separate claim.
<table>
<tr><th>Time Code</th><th>AM</th><th>Time Code</th><th>PM</th></tr>
<tr><td>00</td><td>12:00-12:59 midnight</td><td>12</td><td>12:00-12:59 noon</td></tr>
<tr><td>01</td><td>01:00-01:59</td><td>13</td><td>01:00-01:59</td></tr>
<tr><td>02</td><td>02:00-02:59</td><td>14</td><td>02:00-02:59</td></tr>
<tr><td>03</td><td>03:00-03:59</td><td>15</td><td>03:00-03:59</td></tr>
<tr><td>04</td><td>04:00-04:59</td><td>16</td><td>04:00-04:59</td></tr>
<tr><td>05</td><td>05:00-05:59</td><td>17</td><td>05:00-05:59</td></tr>
<tr><td>06</td><td>06:00-06:59</td><td>18</td><td>06:00-06:59</td></tr>
<tr><td>07</td><td>07:00-07:59</td><td>19</td><td>07:00-07:59</td></tr>
<tr><td>08</td><td>08:00-08:59</td><td>20</td><td>08:00-08:59</td></tr>
<tr><td>09</td><td>09:00-09:59</td><td>21</td><td>09:00-09:59</td></tr>
<tr><td>10</td><td>10:00-10:59</td><td>22</td><td>10:00-10:59</td></tr>
<tr><td>11</td><td>11:00-11:59</td><td>23</td><td>11:00-11:59</td></tr>
</table></td></tr>
<tr><td>19. Admission Type</td><td>Required (Hospital)</td><td>Indicate the applicable code for all inpatient visits. A “1” must be used to indicate an emergency department visit that meets emergency criteria to ensure that a co-payment amount is not deducted during the claim processing.
1 Emergency: The patient requires immediate immediate intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency department.
2 Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.</td></tr>
</table>

Form Locator/Description	**Requirements**	**Explanation**
		3 Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation. 4 Newborn: Any newborn infant admitted to the hospital within the first 24 hours of life.
20. Source of Admission	Required (Hospital)	1 Physician Referral: Inpatient: The patient was admitted to this facility upon the recommendation of their personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral). 2 Clinic Referral: Inpatient: The patient was admitted to this facility upon recommendation of this facility's clinic physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician. 3 HMO Referral: Inpatient: The patient was admitted to this facility upon the recommendation of a health maintenance organization physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a health maintenance physician. 4 Transfer From a Hospital: Inpatient: The patient was admitted to this facility as a transfer from an acute care facility where they were an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.

Form Locator/Description	**Requirements**	**Explanation**
		5 Transfer From a Skilled Nursing Facility: Inpatient: The patient was admitted to this facility as a transfer from a skilled nursing facility where they were an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the skilled nursing facility they were an inpatient. 6 Transfer From Another Health Care Facility: Inpatient: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long-term care facilities, and skilled nursing facility patients that are at a nonskilled level of care. Outpatient: The patient was referred to this facility for outpatient services or referenced diagnostic services by a physician of another health care facility where they are an inpatient. 7 Emergency Department: Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency department physician. Outpatient: The patient was referred to the facility for outpatient services or referenced diagnostic services by this facility's emergency department physician. For Newborns:
20. Source of Admission,	Required (Hospital)	1 Normal Delivery: A baby delivered without complications. 2 Premature Delivery: A baby delivered with time or weight factors qualifying it for premature statu 3 Sick Baby: A baby delivered with medical complications, other than those relating to premature status. 4 Extramural Birth: A baby born in a nonsterile environment. 5-8 Reserved For National Assignment 9 Information Not Available
21. Discharge Hour	Required (Hospital)	**Time Code AM** **Time Code PM**

Form Locator/Description	Requirements	Explanation
		00 12:00-12:59 midnight 01 01:00-01:59 02 02:00-02:59 03 03:00-03:59 04 04:00-04:59 05 05:00-05:59 06 06:00-06:59 07 07:00-07:59 08 08:00-08:59 09 09:00-09:59 10 10:00-10:59 11 11:00-11:59 12 12:00-12:59 noon 13 01:00-01:59 14 02:00-02:59 15 03:00-03:59 16 04:00-04:59 17 05:00-05:59 18 06:00-06:59 19 07:00-07:59 20 08:00-08:59 21 09:00-09:59 22 10:00-10:59 23 11:00-11:59
22. Patient Status	Required (except for ambulance and personal care services)	01 Discharged to home or self care (routine discharge) 02 Discharged/transferred to another short-term general hospital. 03 Discharged/transferred to skilled nursing facility 04 Discharged/transferred to an intermediate care facility. 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution. 06 Discharged/transferred to home under care of organized home health service organization. 07 Left against medical advice. 08 Discharged/transferred to home under care of a home IV provider. 20 Expired. 30 Still a patient or expected to return for outpatient services. 61 Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed. 62 Discharged/transferred to another rehabilitation facility including rehabilitation-distinct part units of a hospital. 63 Discharged/transferred to a long-term care hospital. Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare.

Form Locator/Description	**Requirements**	**Explanation**
23. Medical Record Number	Optional	If a number is entered, it will not appear on the RA.
24. – 30. Condition Codes	Required, where applicable	D7 Medicare Part A non-covered service or does not meet Medicare criteria for Part A. D9 Medicare Part B non-covered service or does not meet Medicare criteria for Part B. Refer to the October 2003 N.C. Medicaid General Bulletin, page 12, for applicable ambulance condition codes. **Note:** Condition codes should not be entered for entitlement issues.
32. - 35., a – b Occurrence Codes and Dates	Required, where applicable	Accident Related Codes: 24 Date Insurance Denied: This code should be should be used when a provider receives a denial from the recipient's third party insurance. It allows the provider to file the claim to Medicaid without a voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party insurance EOB. 25 Date Benefits Terminated By Primary Payer: This code should be used when a recipient's third party insurance has been terminated. It allows the provider to file the claim to Medicaid without the voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party insurance EOB. Note: Medicare crossover claims require a paper insurance denial. Special Codes: A3 Benefits Exhausted: Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer A. B3 Benefits Exhausted: Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer B. C3 Benefits Exhausted: Providers should use this code to indicate the last date for which benefits are available and after which no

Form Locator/Description	**Requirements**	**Explanation**
		payment can be made by payer C. Date of Initial Treatment: Providers should use this code to indicate the first date of dialysis treatment.
39. – 41., a – d Value Codes and Amounts	Required, where applicable	Value codes and amounts pertain only to a long-term care facility, hospital, psychiatric residential treatment facility or, if the recipient lives in a nursing facility, a hospice. Enter any value code pertinent to this claim. Applicable deductible/patient liability amounts Should be indicated with a value code of 23. 23 Recurring Monthly Income: This code indicates that the Medicaid eligibility requirements are determined at the state level. Note: Include code 23 and value (even if it is 0 for any inpatient stay extending beyond the firs of the month following the 30th consecutive da of admission.
42. Revenue Code	Required	Enter the appropriate revenue code. Refer to program-specific Medicaid services information for applicable codes. Revenue code 634 is required for dialysis treatment centers.
43. Revenue Code Description	Not required	
44. HCPCS/Rates	Required, where applicable	Enter the appropriate HCPCS code. Refer to program-specific Medicaid services information for applicable codes.
45. Service Date	Required, where applicable	Enter an 8-digit service date for each line item billed. Required if multiple dates of services are billed on one outpatient claim. Note: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
46. Unit of Service	Required, where applicable	Enter the number of units for each detail line. Refer to program-specific Medicaid services information on how a unit is defined.
47. Total Charges	Required	Enter the total of the amounts in this column. Enter the revenue code 001 on the corresponding line in form locator 42.
50. A, B, C Payer	Required	Enter the Payer Classification Code and Specific Carrier Identification Code for each of up to three payers. List the payers in order of priority: A Primary payer

Form Locator/Description	**Requirements**	**Explanation**
		B Secondary payer C Tertiary payer The information entered on lines A, B, and C must correspond with the information in form locators 37, and 52 through 66. Note: Effective with date of service October 1, 2002, Medicare part B payer codes M0000 must be indicated.
50. A, B, C Payer, continued	Required	Payer Classification Codes Medicare M Medicaid D Blue Cross B Commercial Insurance I Tricare C N.C. DHHS - Purchase of Care N Worker's Compensation W State Employee Health Plan E Administered Plans S Health Maintenance Organization H Self-Pay/Indigent/Charity P Other O Specific Carrier Identification Codes Carrier Payer Classification / Code / Explanatory Notes Medicare (M) / 0000 / 4 zeros Medicaid (D) / XX00 / Where XX= postal state code (example: NC00) Blue Cross (B) / 0XXX / Where XXX= Blue Cross Plan Code or FEP Commercial Insurer (I) / XXXX / Where XXXX= Docket Number Commercial Insurer (I) / 9999 / When Docket Number is Unassigned Tricare (C) / 0000 / 4 zeros NC DHHS – Purchase of Care / 0000 / 4 zeros Worker's Compensation / XXXX / Where XXXX = Docket Number Worker's Compensation / 9999 / When Docket

Form Locator/Description	**Requirements**	**Explanation**
		Number is Unassigned State Employees Health Plan Administered Plan (S) 0000 4 zeros Health Maintenance Organization (H) XXXX Where XXXX= Docket Number Health Maintenance 9999 When Docket Number is Unassigned Self-Pay/Indigent/ Charity (P) 6666 Self-pay hospital bills Patient and Expects Payment
51. A, B, C Provider Number	Required	Enter the Medicaid number as shown on the RA. Do not use extra zeros or dashes.
54. A, B, C, Prior Payments (from payers)	Required, where applicable	For dates of service before October 1, 2002, enter any applicable third party amount. Enter the Medicare Part B payment amount in this block for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim. For dates of service after October 1, 2002: 54A Enter any applicable Medicare payment or third party. 54B If the Medicare payment is indicated in field locator 54A, enter any applicable third party payments in form locator 54B. The Medicare Part B payment amount should be entered for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim. Include penalties and outpatient psychiatric reductions with Medicare Part B payments. Refer to the August 2004 Special Bulletin V, Medicare Part B Billing for detailed instructions. Amounts entered in this block will be deducted from allowable payment.
55. Estimated Amount Due	Required (hospital outpatient)	For claims filed to Medicaid for dates of service after October 1, 2002, where Medicare Part B has made a payment, enter the sum of both the coinsurance and the deductible.
60. A, B, C,	Required	Enter the 10-character MID number as indicated on

Form Locator/Description	**Requirements**	**Explanation**
Certificate/Social Security/ Health Insurance Claim/ Identification Number		the recipient's MID card.
63. A, B, C, Treatment Authorization Code	Not Required	It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
67. Principal Diagnosis Code	Required	Enter the applicable ICD-9-CM diagnosis code.
68. – 75. Other Diagnosis Codes	Required, where applicable	Enter any additional diagnosis codes.
76. Admitting Diagnosis	Required, inpatient only	Enter the ICD-9-CM code for the admitting diagnosis.
80. Principal Procedure Code and Date	Required, where applicable	Enter the codes for any surgical or diagnostic procedures performed during this period. Use only ICD-9-CM procedure codes. Enter the 8-digit date of service. Note: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
81. Other Procedure Codes and Dates	Required, where applicable	Enter the codes for any additional surgical or diagnostic procedures performed during this period. Enter the 8-digit date of service. Note: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
83. b Other Phys. ID	Required, where applicable	For paper claims for services provided to CA enrollees, enter the PCP referral authorization here. For electronic claims, enter the PCP's referral authorization in field locator 11.
84. Remarks	Required, where applicable	Enter any information applicable to the specific claim billed.
85. Provider Representative Signature	Required	The physician, supplier or an authorized representative must either: 1. sign and date all claim, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a Certificate of Signature on File has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.

Form Locator/Description	Requirements	Explanation
86. Date Bill Submitted	Desired	Enter date the claim was submitted.

Billing on the ADA Claim Form

Listed below are some of the provider types who bill on the American Dental Association (ADA) claim form:

- Dentist
- Federally Qualified Health Center (dental services only)
- Health Department Dental Clinics (dental services only)
- Rural Health Clinic (dental services only)

Refer to Clinical Coverage Policy #4, Dental Services, on DMA's Web site at: http://www.dhhs.state.nc.us/dma/mp/mpindex.htm, for instructions on completing the ADA claim form.